

## MBEKI'S HIV/AIDS POLICY COMMUNICATION: THE BELIEFS AND BEHAVIOURS OF A SOUTH AFRICAN COMMUNITY

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### ABSTRACT

*In South Africa by 2002, the number of people living with HIV had risen to 4.7 million with 11% of the population infected. About 25% of the pregnant women in South Africa are HIV positive, and hundreds of infants are infected at birth every day. Amidst this grave public health emergency, President Thabo Mbeki of South Africa sparked a huge international debate during the 13th International AIDS Conference, when he challenged the prevailing AIDS paradigm that HIV causes AIDS, raised questions about the role of AZT as a treatment, and argued that poverty was responsible for the aggressive spread of AIDS in his country. The theoretical body of research implies that communication of political issues from the media influences public perception about these issues. Residents of Ikageng, a suburb of Potchefstroom in South Africa, were purposively sampled because the township was demographically similar to many of the townships in South Africa. Results suggested that President Mbeki's statements may not have played a discernable role in influencing opinion and risk behaviour in this particular sample. This is most likely due to this sample's reliance on other sources for health-related information. The majority of participants reported relying upon medical officials for information about HIV or AIDS. The lack of a direct influence of Mbeki's controversial stance regarding HIV/AIDS on individual risk behaviour, however, may speak to the potential positive and resilient influence of HIV prevention campaigns.*

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## INTRODUCTION

By 1999, South Africa had the highest number of people living with HIV in the world with as many as 4.1 million people and about 20% of the adult population infected (UNAIDS 2001). Three years later, in 2002, the number of people living with HIV had risen to 4.7 million with 11% of the population infected (Associated Press 2002). About 25% of the pregnant women in South African are HIV positive, and hundreds of infants are infected at birth every day (Africa News Service 2001).

Amidst this grave public health emergency, President Thabo Mbeki of South Africa sparked a huge international debate during the 13<sup>th</sup> International AIDS Conference, when he challenged the prevailing AIDS paradigm that HIV causes AIDS, raised questions about the role of AZT as a treatment, and argued that poverty was responsible for the aggressive spread of AIDS in his country (Awofeso, Degeling, Ritchie, & Winters 2001; The Observer 2000). More recently, delegates of Mbeki called the antiretrovirals, which the African National Congress court ordered to be made available to pregnant women (Wales 2002), "poison" (cite commentary from Barcelona).

President Mbeki's challenge of conventionally held beliefs about HIV and AIDS alarmed the medical profession, policy makers, and prevention advocates largely because of fears that such statements made by prominent political leaders might influence the beliefs, perceptions, and even the behaviours of the people of South Africa in a manner that could (exacerbate) the spread of HIV/AIDS in the country. Simply stated, if people believe that HIV is not the cause of AIDS, their perceptions of the consequences of risky behaviours (e.g., unprotected intercourse) would presumably be minimal and, as such, their motivation to perform safer behaviours (e.g., use a condom or abstain from sex) would be insufficient to lead to safer behaviours. Additionally, their fund of accurate information would be limited by what most physicians and scientists would consider to be *misinformation*.

In short, the *research problem* investigated dealt with: President's Mbeki's HIV/AIDS policy communication and the influence thereof on the beliefs and behaviours of a selected community in the North West Province of South Africa.

## THEORETICAL FRAMEWORK DISCUSSION

The influence of political communications on public opinion has been studied extensively for decades. Certain personality characteristics such as emotional instability, phobia, and fatalism, as well as social categories such as religion and education affected some individuals to perceive statements from radio about an invasion from Mars as being true which led them to panic (Cantril 1940). Political propaganda has been shown to activate and reinforce latent predispositions among individuals in different social categories (Lazarsfeld, Berelson, & Gaudet 1948). However, it has also been hypothesized that political ideas often flow from the media to opinion leaders that convey it to those who are less active in the communication process (Lazarsfeld, Berelson, & Gaudet 1948). Consequently, other scholars argue that personal influence plays a major role in the communication process of political information (Katz & Lazarsfeld 1955).

Some studies show that political communication through the media affect public opinion gradually and cumulatively and therefore it is easy to underestimate their influence (Noelle-Nueman 1973; Hertog & Fan 1995). Numerous scholars argue that by emphasizing certain issues in the communication of political ideas the media shapes what the public perceives as the most important issues for discussion (McCombs & Shaw 1972; McCombs 1992; Weaver, Graber, McCombs & Eyal 1981; Fan, Brosius & Keplinger 1994; Becker, McCombs & McLeod 1975; Shaw & Martin 1992; Kim, Scheufele & Shanahan 2002). On the other hand some scholars have extended the original agenda-setting theory to the agenda building process. The premise is that the communication of political ideas involves the media agenda, the political agenda and the public agenda and that there is a tripartite relationship between them (Lang & Lang 1983; Dearing & Rogers 1988). Some scholars further suggest that interpersonal communication plays a major role in reinforcing public opinion in the agenda building process (Wanta & Wu 1992; Larsosa & Wanta 1990; Weaver, Zhu & Willnat 1992). At the same time some scholars argue that the press coverage of HIV influences the public's beliefs about HIV transmissions routes (Hertog & Fan 1995). However, other scholars argue that in order for such beliefs to persist, the information or idea from whatever source must agree with the predisposition of the individual because contrary information is likely to be ignored (Nicol, Laukamm-Josten, Mwizarubi et al. 1993). The suggestion that the influence of information from the media on the public opinion is sometimes under estimated because it is cumulative and long-term (Noelle-Nueman 1973).

This body of research implies that communication of political issues from the media influences public perception about these issues. President Mbeki's skepticism about the causes and treatment of AIDS may have undermined media campaign efforts to promote safer behaviours and created an environment where the messages of health care workers and prevention specialists were called into question as a function of the messages of a powerful and respected political leader. It is reasonable to assume that one set of messages challenged the other, but whether Mbeki's well-publicised challenge thwarted prevention campaign messages is not certain. Nor is it clear whether the political controversy filtered into the everyday life and individual behaviour of the average South African.

On the other hand, most well-supported theories of behaviour and behaviour change (e.g., the IMB model: Fisher & Fisher 1992, 2000, 2002; the Theory of Reasoned Action: Ajzen 1991; Fishbein et al. 1994; the Theory of Planned Behaviour: Ajzen 1991; Social Cognitive Theory: Bandura 1994; Observational Learning: Bandura 1994; the Elaboration Likelihood Model: Petty & Cacioppo 1981, 1986a, 1986b, Petty & Priester 1994) would predict that such a "misinformed" and poorly motivated individual would be unlikely to consistently practice safer behaviour (e.g., condom use or clean needle use). The effects of this well-publicised debate and the ensuing controversies on the average South African are unknown and are worthy of exploration.

The concern for the potential ill effect on public health and individual behaviour of President Mbeki's statements is well-founded according to classic theories of

communication impact (e.g., Katz & Lazarsfeld 1955; Noelle-Nueman 1973). President Mbeki's scepticism about the causes and treatment of AIDS may have undermined media campaign efforts to promote safer behaviours, and created an environment where the messages of health care workers and prevention specialists were called into question as a function of the messages of a powerful and respected political leader. It is reasonable to assume that one set of messages challenged the other, but whether Mbeki's well-publicised challenge thwarted prevention campaign messages is not certain. Nor is it clear whether the political controversy filtered into the everyday life and individual behaviour of the average South African.

The Information, Motivation, and Behavioural Skills model of HIV risk prevention behaviour (Fisher & Fisher 1992, 2000, 2002) suggests that the degree to which any statement by an "other" influences behaviour is largely dependent on the extent to which that "other's" message is incorporated into one's fund of information and the extent to which the opinion or message creates normative support for a particular behaviour. Within the parameters of the IMB model, Mbeki's statements would not be presumed to have a direct impact on individual behaviour unless there is "buy-in" into the actual information (e.g., "HIV may not cause AIDS"), and there is a translation from exposure to the message to an actual decrease in motivation toward practicing preventative behaviours, through attitude formation (e.g., "I don't believe that I need to use a condom to protect myself"; "I don't believe that condoms protect you from AIDS"), normative support (e.g., "Most people don't use condoms"), and/or perceived vulnerability (e.g., "I am not at risk of getting HIV/AIDS through unprotected sex"). For any of these influences to occur, the individual must, at minimum, believe President Mbeki's assertion that HIV may not be the cause of AIDS and then draw the conclusion that unprotected sexual intercourse or unclean needle use is therefore not dangerous to his or her health. Despite considerable attention devoted to Mbeki's statements, there has not yet been an assessment of the extent to which South Africans have "bought into" or believed in the assertion that HIV may not cause AIDS, nor has there been an evaluation of the extent to which such beliefs influence safer behaviours (e.g., condom use).

Bandura's (1994) Social Cognitive Theory explores ways in which human communication affects the thought process, the individual's affect and consequent behaviour. The theory suggests that behaviour is shaped by various factors including cognitive, biological and other personal characteristics, as well as environmental events that influence each other in a bidirectional way. These factors enable individuals to exercise some degree of self control. This implies that individuals in South Africa can exercise some control over their behaviour no matter what Mbeki says about the causes of AIDS. Even if they trusted and liked him as a person, they do not necessarily have to agree and hence adopt risky behaviours simply because Mbeki says HIV does not cause AIDS. The Observational Learning Model (Bandura 1994) argues that there are attention processes that make people to selectively observe, process, and retain information. This means that Mbeki's statements would not be taken at their face value. People can decide whether to listen to him, cognitively process what he said and make a decision whether to believe and adopt risky sexual behaviours. Furthermore, the

Elaboration Likelihood Model (Petty & Cacioppo 1981, 1986a, 1986b; Petty & Priester 1994) suggests two routes to persuasion. The first, the central route, involves some cognitive effort to analyse carefully all pertinent information to determine the merits of the advocated position. This route involves motivation to process information in the same way as suggested by Fisher & Fisher (1992, 2000, 2002). Consequently, a positive or negative response to the advocated message will be taken by the individual. The second, the peripheral route, argues that if the individual's motivation to process information is low, persuasion can easily occur. This implies that people who have higher motivation to process Mbeki's statement, such as the more educated, are less likely to agree with his position about the cause of AIDS while those with lower motivation could easily be persuaded to adopt his position on this issue.

In an international collaboration, we sought to provide an initial evaluation of the individual level effects of President Mbeki's statements on sexual risk behaviours. We were particularly interested in the extent to which individuals believed the controversial statement that HIV may not cause AIDS and the degree to which that belief influences the sexual risk behaviours of a sample of South African participants in Potchefstroom.

## **RESEARCH METHOD**

### **Overview**

Survey instruments assessing information and beliefs about the cause of AIDS and actual sexual risk behaviours over the last three months were administered in English with interviewer assistance. Residents of Ikageng, a suburb of Potchefstroom in the North West Province of South Africa, were purposively sampled because the township was demographically similar to many of the townships in South Africa. The township has a population of 180,000 residents, most of whom are Black, and it has an unemployment rate of over 50%. After explaining the study and obtaining informed consent, five trained interviewers conducted 30-minute interviews in the homes of the participants. Participants were not offered monetary reimbursement for completing a survey. The resulting 303 interviews were evaluated in terms of demographics and the association between reported risk behaviours and reported beliefs in the veracity of President Mbeki's policy statements regarding HIV/AIDS.

### **Participants**

Participants were selected as a convenience purposive sample. Three-hundred-and-three participants from the Ikageng township (149 men, 148 women and 6 unidentified) between the ages of 15 to 40 (mean age of 26) participated in the current study. All participants were Black and predominantly Christian (284). The reported tribal membership represented the majority of local tribes including Tswana (60%), Xhosa (10.6%), Sotho (14.9%), Zulu (3.6%) and Tonga (1%). Participant education levels suggested a relatively high literacy/education level, with 11 (3.6%) reporting finishing primary school, 203 (67%) finishing secondary school, 42 (13.9%) finishing post secondary school, and 23 (7.6%) finishing graduate studies. The average yearly salary was 21655 rand, roughly \$1,883.04 US dollars, and 61% denied having access to free

medical treatment. Of the 303 participants, 33 (11%) were married and 241 (82%) reported having had sexual intercourse at least once in their lifetime, while 52 reported never having had intercourse (10 did not respond to this question).

### **Procedures**

Respondents were recruited for participation through individual contact on the street, at the individual's house, or at the local store. Each respondent was briefed by the interviewer in terms of intent of study, requirements of participation, confidentiality of responses, and the structure of the survey. The surveys were then administered to each respondent individually, and the interviewer was present during the interviewing process to address any questions or concerns. Because of the relatively high literacy rate of the interviewees, they were encouraged to complete the surveys independently. In order to minimize any potential impact of interviewer characteristics on responses, the interviewers provided assistance only when necessary. During the survey, only the interviewer and interviewee were present, in order to avoid any outside interference from other household members. The data collection team in South Africa reported that approximately 60 interviews were collected by each of the 5 trained interviewers. Because of a data recording/collection error, we were unable to assess for any potential direct impact of interviewer on participant responses.

In order to ensure greater *validity and reliability*, proper training was provided to the interviewers. A pilot study was also conducted to ensure that the procedures and process were well managed. In a few instances procedural problems were experienced but these were rectified without any trouble.

### **RESULTS**

In terms of general sexual behaviours within the sample, 82% (241 participants) reported having had sexual intercourse at some point in their life. Of these individuals, 66% (162) reported sexual activity in the last 3 months. The majority (83%: 135) of the individuals reporting sexual activity in the past 3 months also reported having had discussed safer sex (condom use) with a partner prior to intercourse. Similarly, 69% (112) of sexually active participants reported keeping condoms readily available, while 30% (49) reported doing so inconsistently or never. In terms of actual condom use, 59% (95) of those reporting current sexual activity always used condoms, 6% (10) often used them, 11% (17) sometimes, 3% (4) rarely, and 22% (35) never used condoms. Of the sexually active participants, 94% provided estimations of percentage of time a condom was used during sexual events over the last three months. Fifty-four percent reported 100% condom use, while 46% reported percentages less than 100% for condom use during sexual events over the last three months. The average percentage of condom use was 68%. Men and women differed significantly in the percentage of condom use reported ( $t=2.35$ ,  $p = .021$ ), with men ( $n=71$ ) averaging 77% of the time and women (51) averaging 59% of the time. Participants were classified into a "risk" group if there were any reported unprotected sexual events (e.g., if percentage condom use over the last three months was less than 100%) and into a "low risk" group if condom use was 100%. Because this definition of risk regards consistent condom use, only those

participants who were sexually active over the last three months were included in this grouping variable.

We were particularly interested in the potential effects of HIV prevention messages and campaigns on this sample of participants. Participants completed a segment of the questionnaire that assessed general sources of information regarding HIV and the perceived reliability of various information sources. Given the well-publicised statements of President Mbeki and his scientific team asserting that HIV may *not* be the cause of AIDS, we were interested in the extent to which such statements were influential to the typical South African in our sample and the extent to which such an influence was associated with HIV risk behaviours. All participants were asked to state their belief about what causes AIDS, who they trust for information about HIV and AIDS, and the extent to which they agree with President Mbeki's contention that HIV may not cause AIDS.

When asked in an open-ended format about what they think is the cause of AIDS, the vast majority of participants (71% or 202) reported that AIDS was caused by unsafe sexual practices, while 16% (47) reported causes such as STDs and HIV. In terms of sources of accurate HIV and AIDS information, participants clearly placed more faith in information obtained from health officials than other officials. Table 1 demonstrates that while small proportions of the sample trusted clan, religious, political, and government leaders, most participants placed their trust in medical officials for information regarding HIV and AIDS.

**Table 1: Who would you trust for information about HIV or AIDS?**

Source	Yes	No
Religious Leaders	29% (84)	71% (207)
Clan Leaders	2% (5)	98% (286)
Tribal Leaders	2% (6)	98% (285)
Political Leaders	8% (22)	92% (269)
Government Leaders	13% (38)	87% (253)
Medical Officers	72% (209)	28% (82)

While the majority of participants liked President Mbeki (65%) and generally trusted him as a leader (65%), most disagreed (71%) with his assertion that HIV does not cause AIDS. We did find that those who reported *liking* President Mbeki tended to also report *trusting* him ( $r = .660, p = .000$ ), *believing* in the President's views regarding general public concerns ( $r = .202, p = .001$ ) and *agreeing* with his views on HIV not causing AIDS ( $r = .138, p = .02$ ). We did not, however, find support for an association between

participants believing in President Mbeki's assertion that HIV does not cause AIDS and participant risk behaviour. There was no difference between those with risk and those with low risk in terms of the extent to which they agreed with President Mbeki's statement ( $F(1,120)=1.67, p=.684$ ); both groups reported generally disagreeing with the statement. We did find slight, though significant, discrepancies between the risk groups in terms of how much they *liked* Mbeki, with those reporting 100% condom use tending to like the president slightly more than those reporting less than 100% condom use in the past three months ( $F(100) = 8.29, p=.005$ ). Similarly, those who reported using condoms 100% of the time reported a slightly higher average degree of *trust* of Mbeki than those who engaged in some risk behaviour ( $F(99) = 9.21, p=.003$ ). These discrepancies in liking and trust, however, were qualitatively quite small, translating to average differences of "not sure" (like or trust) for the low risk group versus (like or trust) "a little" for the risk group.

## DISCUSSION/CONCLUSIONS

The statements of South African President Thabo Mbeki prior to, and during the 13<sup>th</sup> International AIDS Conference that challenged the prevailing belief HIV causes AIDS, has caused considerable alarm and concern in the international scientific community. (The Observer 2000). The alarm primarily stems from the potential ramifications that such statements, which are directly in conflict with HIV/AIDS prevention campaign statements, can have on public and individual risk prevention behaviours. Classic theories regarding the impact of well-publicised events (e.g., Lazarsfeld, Berelson & Gaudet's (1948) two-stage flow theory of communication or McCombs & Shaw's (1972) agenda-setting theory) suggest that messages from public officials in the media often influence opinion at the community level, through the influence of norms and environmental press, and at the individual level, through the influence on attitude formation. Theories of individual level behaviour change, such as the Information, Motivation, Behavioural Skills model (Fisher & Fisher 1992, 2000, 2002), Social Cognitive Theory (Bandura 1994), Observational Learning (Bandura 1994), the Elaboration Likelihood Model (Petty & Cacioppo 1981, 1986a, 1986b; Petty & Priester 1994) similarly recognise the potential for official messages to influence individual behaviours, with the degree of influence being predicted by the extent to which such messages infiltrate an individual's fund of prevention-related information, motivation, and behavioural skills. In this study, we assessed the degree to which President Mbeki's public statements regarding the causes of AIDS were adopted by residents of a typical South African township and the degree to which sexual risk-taking behaviours were associated with the belief that AIDS is not caused by HIV.

Results indicated that participants did engage in sexual risk behaviours over the three months prior to completing the survey. Of the participants who were sexually active, 59% reported "always" using a condom, 6% used them "often," 11% "sometimes" and 22% reported "never" using a condom. When asked to estimate the percentage of time they used a condom during sexual events over the last three months, participants reported similar proportions, with 54% reporting 100% condom use, and 46% reporting less than 100%. Men reported a significantly higher percentage of condom use (averaging 77%) than female respondents (averaging 59%).

We assessed the extent to which sexual risk was associated with believing in Mbeki's assertion that HIV does not cause AIDS. The majority of participants reported disagreeing with Mbeki's statement that HIV does not cause AIDS (30% strongly disagreed and 41% disagreed). There did appear to be sufficient variability in this area, with 19% reporting being uncertain about Mbeki's statement, 4% reporting agreement, and 5% strongly agreeing. We did not find a relation between level of *agreement* with Mbeki and actual practice of risk behaviours, although participants reporting some degree of risk over the last three months tended to score slightly higher on *liking* and *trusting* the president than those reporting no risk. Qualitatively, however, the mean differences reflected differences between "not sure" and "a little" on the "liking" and "trusting" items.

Results suggested that President Mbeki's statements may not have played a discernable role in influencing opinion and risk behaviour in this particular sample. This is most likely due to this sample's reliance on other sources for health-related information. The majority of participants reported relying upon medical officials for information about HIV or AIDS. Only a small portion reported relying upon government officials for such information (13% of the sample). The majority of respondents reported believing that the cause of AIDS is unsafe sex (71%), with an additional 16% specifically citing HIV. Perhaps participants are resistant to incorporating Mbeki's message because they do not believe that he is a credible source of medical information. Thus, while he may be well-liked and respected as a political leader, he may not be viewed as a leader on medical issues, such as HIV. The association we found between liking and trusting Mbeki and risk does not appear to be due to a higher tendency towards believing in Mbeki's assertion that HIV does not cause AIDS. The underlying causes of the reported risk behaviour are likely beyond the scope of the brief survey completed by participants. What is clear, however, is that health promotion campaigns in South Africa appear to exert a stronger influence on the beliefs of South Africans than the well-publicized political debates about the genesis of AIDS. According to this sample, South Africans rely on medical officials for information relevant to health and do not appear to share the President's convictions about AIDS and HIV. Even for those that do share the President's convictions, there does not appear to be a translation from this belief into unsafe practice. In an IMB model context, there are likely several other influences at play. Subscribing to the President's theory of AIDS is not likely to be sufficient to produce an impact on behaviour. For example, believing that HIV does not cause AIDS does not mean that one also believes that unprotected sexual intercourse is safe (in terms of pregnancy or other STDs), thus one's sense of perceived vulnerability to negative consequences of unprotected sex may be intact. Alternatively, one could strongly disagree with Mbeki and still feel personally invulnerable to HIV or STDs because of faulty heuristics (e.g., "I can tell if someone has HIV or an STD so I am not at risk"). Also, the belief in Mbeki's statement does not speak to one's normative support about safer behaviour (e.g., one could believe Mbeki but also believe one's peers, family, or community's beliefs about condom use).

Because of purposive sampling, the results of the current study may not be representative of the general South African population. For instance while the Tswana make up 60% of our sample, other tribes such as the Tsonga have much smaller percentages and some South African tribes are not represented at all. Thus, results must be understood in the context of the particular sample of South Africans we recruited. Additionally, the brevity of the survey, global nature of the survey items, and cross-sectional design did not allow for more fine grained analyses of how the well publicised controversy between Mbeki and scientists/health officials may have impacted on determinants of risk behaviour in a causal manner. The brief survey measure used in the present research does provide an initial assessment of the extent to which South African residents shared the HIV/AIDS belief of President Mbeki, and if those beliefs related to risk behaviour. Put as a simple, straightforward question, we found the answer to be 'no'. The underlying factors that may have been influenced by Mbeki's well-publicised challenges were beyond the scope of the current assessment. We were interested in establishing the presence of gross level effects on individual behaviour, which we did not find. It is possible that Mbeki's messages played a more subtle role in influencing behaviour, and that actual risk behaviour could be best predicted by a multivariate approach. Assessing the potential influence of the message in areas of prevention information, motivation, and behavioural skills may provide a more thorough evaluation of potential influence. The lack of a direct influence of Mbeki's controversial stance regarding HIV/AIDS on individual risk behaviour, however, may speak to the potential positive and resilient influence of HIV prevention campaigns. Given that most respondents reported relying upon medical officials for HIV/AIDS information, perhaps the most valuable efforts of the international scientific community and media should be directed toward supporting and reinforcing the ongoing efforts health officials and direct care workers in delivering HIV risk reduction counselling and community level prevention programs rather than arguing with Mbeki about the cause of AIDS.

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